

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0037960</div> <div>Facility Name: COLUMBUS PARK NRSG REHAB CTR</div> <div>Address: 901 SOUTH AUSTIN CHICAGO 60644</div> <div>County: COOK</div> <div>Telephone Number: (773) 287-5959 Fax # (773) 287-7909</div> <div>IDPA ID Number: 363801333001</div> <div>Date of Initial License for Current Owners: 01/01/92</div> <div>Type of Ownership:</div> <div><div><div><div></div><div>VOLUNTARY,NON-PROFIT</div><div></div><div>Charitable Corp.</div><div></div><div>Trust</div><div>IRS Exemption Code</div></div><div><div>X</div><div>PROPRIETARY</div><div></div><div>Individual</div><div></div><div>Partnership</div><div></div><div>Corporation</div><div>X</div><div>"Sub-S" Corp.</div><div></div><div>Limited Liability Co.</div><div></div><div>Trust</div><div></div><div>Other</div></div><div><div></div><div>GOVERNMENTAL</div><div></div><div>State</div><div></div><div>County</div><div></div><div>Other</div></div></div><div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) CARY C. BUXBAUM, C.P.A.</div><div>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

COLUMBUS PARK NRSRG REHAB CTR

#

0037960

Report Period Beginning:

01/01/02

Ending:

12/31/02

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,420	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	15,139	422	1,489	17,050	8
9	SNF/PED					9
10	ICF	51,642	1,441	210	53,293	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,781	1,863	1,699	70,343	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

89.22%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?  
1,501 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 01/01/92

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 01/01/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 19 and days of care provided 1,427

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	217,453	41,062	35,832	294,347		294,347	(21,015)	273,332		1
2	Food Purchase		308,589		308,589	(28,908)	279,681	(81)	279,600		2
3	Housekeeping	175,285	28,544		203,829		203,829	738	204,567		3
4	Laundry	68,652	31,219		99,871		99,871		99,871		4
5	Heat and Other Utilities			158,462	158,462		158,462	2,322	160,784		5
6	Maintenance	41,428	11,146	120,272	172,846		172,846	(29,983)	142,863		6
7	Other (specify):*							5,911	5,911		7
8	<b>TOTAL General Services</b>	502,818	420,560	314,566	1,237,944	(28,908)	1,209,036	(42,108)	1,166,928		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	2,069,772	102,241	56,449	2,228,462		2,228,462	(32,920)	2,195,542		10
10a	Therapy	115,875	2,782	10,223	128,880		128,880		128,880		10a
11	Activities	94,204	8,128	3,866	106,198		106,198		106,198		11
12	Social Services	98,035		3,572	101,607		101,607		101,607		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							4,556	4,556		15
16	<b>TOTAL Health Care and Programs</b>	2,377,886	113,151	74,110	2,565,147		2,565,147	(28,364)	2,536,783		16
	<b>C. General Administration</b>										
17	Administrative	107,751		518,162	625,913		625,913	(360,891)	265,022		17
18	Directors Fees										18
19	Professional Services			180,087	180,087		180,087	(110,002)	70,085		19
20	Dues, Fees, Subscriptions & Promotions			32,758	32,758		32,758	(15,390)	17,368		20
21	Clerical & General Office Expenses	102,925	24,514	71,513	198,952		198,952	7,098	206,050		21
22	Employee Benefits & Payroll Taxes			525,723	525,723	28,908	554,631		554,631		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,993	2,993		2,993	279	3,272		24
25	Other Admin. Staff Transportation			80	80		80	2,832	2,912		25
26	Insurance-Prop.Liab.Malpractice			119,656	119,656		119,656	1,214	120,870		26
27	Other (specify):*							26,993	26,993		27
28	<b>TOTAL General Administration</b>	210,676	24,514	1,450,972	1,686,162	28,908	1,715,070	(447,867)	1,267,203		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,091,380	558,225	1,839,648	5,489,253		5,489,253	(518,339)	4,970,914		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,072	57,072		57,072	372,065	429,137			30
31	Amortization of Pre-Op. & Org.							20,807	20,807			31
32	Interest			40,190	40,190		40,190	548,958	589,148			32
33	Real Estate Taxes			150,443	150,443		150,443	6,307	156,750			33
34	Rent-Facility & Grounds			985,500	985,500		985,500	(698,193)	287,307			34
35	Rent-Equipment & Vehicles			5,611	5,611		5,611	8,262	13,873			35
36	Other (specify):*											36
37	TOTAL Ownership			1,238,816	1,238,816		1,238,816	258,207	1,497,023			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,186	87,195	161,381		161,381		161,381			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		74,186	205,455	279,641		279,641		279,641			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,091,380	632,411	3,283,919	7,007,710		7,007,710	(260,133)	6,747,577			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,136)	30		9
10	Interest and Other Investment Income	(21)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(81)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,384)	21		24
25	Fund Raising, Advertising and Promotional	(3,870)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,294)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,680)	20		28
29	Other-Attach Schedule	(182,108)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (273,574)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,441		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,441		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (260,133)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
COLUMBUS PARK MSG REHAB CTR		
ID# 0037960		
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
NON-ALLOWABLE EXPENSES		Sch. V Line
		Amount Reference
1	VA Prescription Drugs	(5,920) 10 1
2	Trust Fees	(75) 20 2
3	IL Council on LTC - COPE	(3,010) 20 3
4	Capitalized R&M	(14,133) 06 4
5	Tower Rent	(9,600) 34 5
6	Phone Rent	(1,699) 34 6
7	Jury Duty	0100 10 7
8	Non-Care related Legal	(1,532) 19 8
9	Contributions - Building Company	(136,500) 20 9
10	Professional Fees - Building Co	(9,240) 19 10
11	LLC Fees	(83) 21 11
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101	Total	(182,108) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COLUMBUS PARK NRSRG REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					(21,015)							(21,015)	1
2	Food Purchase	(81)											(81)	2
3	Housekeeping			738									738	3
4	Laundry													4
5	Heat and Other Utilities			927	1,395								2,322	5
6	Maintenance	(14,133)		654	(12,496)	(4,008)							(29,983)	6
7	Other (specify):*				1,059	4,852							5,911	7
8	TOTAL General Services	(14,214)		2,319	(10,042)	(20,171)							(42,108)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,229)			(20,793)			(5,898)					(32,920)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,556								4,556	15
16	TOTAL Health Care and Programs	(6,229)			(16,237)			(5,898)					(28,364)	16
	C. General Administration													
17	Administrative			17,066	(66,278)	(311,297)			(382)				(360,891)	17
18	Directors Fees													18
19	Professional Services	(10,772)	9,240	(103,165)	(12,202)	6,890			7				(110,002)	19
20	Fees, Subscriptions & Promotions	(152,142)	136,500	228	20				4				(15,390)	20
21	Clerical & General Office Expenses	(55,761)	23	57,093	5,710				33				7,098	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			45	234								279	24
25	Other Admin. Staff Transportation			670	2,162								2,832	25
26	Insurance-Prop.Liab.Malpractice			500	714								1,214	26
27	Other (specify):*			11,070	6,268	9,571			84				26,993	27
28	TOTAL General Administration	(218,674)	145,763	(16,493)	(63,372)	(294,836)			(254)				(447,867)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(239,118)	145,763	(14,174)	(89,651)	(315,007)		(5,898)	(254)				(518,339)	29

## Summary B

<b>Facility Name &amp; ID Number</b>	<b>COLUMBUS PARK NRSG REHAB CTR</b>	<b>#</b>	<b>0037960</b>	<b>Report Period Beginning:</b>	<b>01/01/02</b>	<b>Ending:</b>	<b>12/31/02</b>
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## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(23,136)	389,301	2,433	3,467								372,065	30
31	Amortization of Pre-Op. & Org.		20,807										20,807	31
32	Interest	(21)	543,767	1,237	3,975								548,958	32
33	Real Estate Taxes			2,191	4,116								6,307	33
34	Rent-Facility & Grounds	(11,299)	(686,894)										(698,193)	34
35	Rent-Equipment & Vehicles			3,314	4,948								8,262	35
36	Other (specify):*													36
37	TOTAL Ownership	(34,456)	266,982	9,175	16,506								258,207	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(273,574)	412,744	(4,999)	(73,145)	(315,007)		(5,898)	(254)				(260,133)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 985,500	Columbus Park Associates Partnership	100.00%	\$	\$ (985,500)	1
2	V	33	RENTAL INCOME - R/E TAX	150,443	Columbus Park Associates Partnership	100.00%		(150,443)	2
3	V	32	INTEREST INCOME	10,633	Columbus Park Associates Partnership	100.00%		(10,633)	3
4	V	34	RENT EXPENSE		Columbus Park Associates Partnership	100.00%	298,607	298,607	4
5	V	33	REAL ESTATE TAX EXPENSE		Columbus Park Associates Partnership	100.00%	150,443	150,443	5
6	V	31	AMORTIZATION		Columbus Park Associates Partnership	100.00%	20,807	20,807	6
7	V	30	DEPRECIATION		Columbus Park Associates Partnership	100.00%	389,301	389,301	7
8	V	32	MORTGAGE INTEREST		Columbus Park Associates Partnership	100.00%	554,400	554,400	8
9	V	20	CONTRIBUTIONS		Columbus Park Associates Partnership	100.00%	136,500	136,500	9
10	V	21	G&A EXPENSE		Columbus Park Associates Partnership	100.00%	23	23	10
11	V	19	PROFESSIONAL FEES		Columbus Park Associates Partnership	100.00%	9,240	9,240	11
12	V								12
13	V								13
14	Total			\$ 1,146,575			\$ 1,559,320	\$ * 412,744	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 738	\$ 738	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	927	927	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	654	654	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,066	17,066	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,645	2,645	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	228	228	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	57,093	57,093	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	45	45	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	670	670	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	500	500	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,070	11,070	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,433	2,433	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,237	1,237	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,191	2,191	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,314	3,314	29
30	V								30
31	V								31
32	V	19	ACCOUNT/BOOKKEEPING	105,810	PREFERRED BOOKKEEPING	100.00%		(105,810)	32
33	V	19	COMPUTER	5,184	PREFERRED BOOKKEEPING	100.00%	5,184		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 110,994			\$ 105,995	\$ * (4,999)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,395	\$ 1,395	15
16	V	6	REPAIRS AND MAINT.	19,440	S.I.R. MANAGEMENT, INC.	100.00%	6,944	(12,496)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,059	1,059	17
18	V	10	NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	21,975	(20,793)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,556	4,556	19
20	V	17	ADMINISTRATIVE	75,816	S.I.R. MANAGEMENT, INC.	100.00%	9,538	(66,278)	20
21	V	19	PROFESSIONAL FEES	17,496	S.I.R. MANAGEMENT, INC.	100.00%	5,294	(12,202)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	20	20	22
23	V	21	CLERICAL & GENERAL	22,032	S.I.R. MANAGEMENT, INC.	100.00%	27,742	5,710	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	234	234	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,162	2,162	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	714	714	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,268	6,268	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,467	3,467	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,975	3,975	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,116	4,116	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,948	4,948	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 177,552			\$ 104,407	\$ * (73,145)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 22,032	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,943	\$ (15,089)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,439	1,439	16
17	V	17	ADMIN./LEGAL SALARIES	366,026	S.I.R. MANAGEMENT, INC.	100.00%	43,515	(322,511)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,666	14,666	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,427	7,427	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	7,730	7,730	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,241	1,241	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	6,004	6,004	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	903	903	25
26	V								26
27	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V								29
30	V	6	REPAIRS AND MAINT.	12,600	S.I.R. MANAGEMENT, INC.	100.00%	8,592	(4,008)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,781	1,781	31
32	V								32
33	V	1	DIETICIAN SALARIES	13,800	S.I.R. MANAGEMENT, INC.	100.00%	7,874	(5,926)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,632	1,632	34
35	V								35
36	V	19	LEGAL FEES	7,776	S.I.R. MANAGEMENT, INC.	100.00%		(7,776)	36
37	V								37
38	V	17	COUNCIL DUES	2,520	S.I.R. MANAGEMENT, INC.	100.00%		(2,520)	38
39	Total			\$ 424,754			\$ 109,747	\$ * (315,007)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 110,907	\$ 110,907	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	110,907	CCS EMPLOYEE BENEFIT GROUP	100.00%		(110,907)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 110,907			\$ 110,907	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	XCEL Medical Supply, LLC	100.00%	\$	\$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	43,534	XCEL Medical Supply, LLC	100.00%	37,636	(5,898)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 43,534			\$ 37,636	\$ * (5,898)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	ECM OWNERS COUNCIL	100.00%	\$ 7	\$	7
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	4		4
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	33		33
18	V	17	MANAGEMENT FEES	1,800	ECM OWNERS COUNCIL	100.00%			(1,800)
19	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	1,418		1,418
20	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	84		84
21	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 1,800			\$ 1,546	\$ *	(254)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COLUMBUS PARK NRSG REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	3.77%	See attached	0.71	0.99%	SIR salary	\$ 1,973	17-7	1
2	Noah Wolff	Shareholder	Administrative	4.25%	See attached			Mgmt Fees	36,000	17-3	2
3	Leo Feigenbaum	Shareholder	Administrative	13.21%	See attached	1	1.52%	Mgmt Fees	36,000	17-3	3
4	Bryan Barrish		Administrative		See attached	1.63	4.66%	SIR salary	7,730	17-7	4
5	Mike Giannini		Administrative		See attached	1.87	4.68%	SIR, ECMOC	7,422	17-7	5
6	Arturo Rominiquit	Relative	Clerical		See attached	4.14	11.29%	Pref Bookk	2,668	21-7	6
7	Nenita Guzman	Shareholder	Dietary	1.89%	See attached	5.6	11.20%	SIR salary	6,943	1-7	7
8	Tom Winter	Shareholder	Administrative	0.94%	See attached	6.77	11.28%	Pref Bookk	17,066	17-7	8
9	Louise Bergthold	Shareholder	Administrative	4.25%	See attached	6.16	11.20%	SIR salary	19,939	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 135,741		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES  
Street Address: 4100 WEST PRATT AVE.  
City / State / Zip Code: LINCOLNWOOD, IL. 60712  
Phone Number: (847) 674-5200  
Fax Number: (847) 674-5267

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	938,058	11	\$ 6,541	\$	105,810	\$ 738	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	938,058	11	8,219		105,810	927	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	938,058	11	5,799		105,810	654	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	938,058	11	151,295	151,295	105,810	17,066	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	938,058	11	23,448		105,810	2,645	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	938,058	11	2,020		105,810	228	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	938,058	11	506,159	442,988	105,810	57,093	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	938,058	11	400		105,810	45	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	938,058	11	5,937		105,810	670	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	938,058	11	4,435		105,810	500	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	938,058	11	98,137		105,810	11,070	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	938,058	11	21,566		105,810	2,433	12
13	32	INTEREST	BOOK./ACCNT.INCOME	938,058	11	10,965		105,810	1,237	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	938,058	11	19,425		105,810	2,191	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	938,058	11	29,379		105,810	3,314	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,184	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 893,725	\$ 594,283		\$ 105,995	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSG REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.  
Street Address 6840 N. LINCOLN  
City / State / Zip Code LINCOLNWOOD, IL. 60712  
Phone Number ( 847) 675 -7979  
Fax Number ( 847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	628,177	10	\$ 12,461	\$ 70,343	70,343	\$ 1,395	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	628,177	10	62,016	45,622	70,343	6,944	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	628,177	10	9,458		70,343	1,059	3
4	10	NURSING	PATIENT DAYS	628,177	10	196,243	196,243	70,343	21,975	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	628,177	10	40,682		70,343	4,556	5
6	17	ADMINISTRATIVE	PATIENT DAYS	628,177	10	85,174	85,174	70,343	9,538	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	628,177	10	47,273		70,343	5,294	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	628,177	10	176		70,343	20	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	628,177	10	247,745	202,804	70,343	27,742	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	628,177	10	2,093		70,343	234	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	628,177	10	19,306		70,343	2,162	11
12	26	INSURANCE	PATIENT DAYS	628,177	10	6,377		70,343	714	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	628,177	10	55,976		70,343	6,268	13
14	30	DEPRECIATION	PATIENT DAYS	628,177	10	30,963		70,343	3,467	14
15	32	INTEREST	PATIENT DAYS	628,177	10	35,501		70,343	3,975	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	628,177	10	36,759		70,343	4,116	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	628,177	10	44,185		70,343	4,948	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 932,388	\$ 529,843		\$ 104,407	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization S.I.R. MANAGEMENT, INC.  
Street Address 6840 N. LINCOLN  
City / State / Zip Code LINCOLNWOOD, IL. 60712  
Phone Number ( 847) 675 -7979  
Fax Number ( 847) 675 -0555

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	\$ 62,004	\$ 62,004	70,343	\$ 6,943	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		70,343	1,439	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	70,343	43,515	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		70,343	14,666	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	\$ 66,321	\$	70,343	\$ 7,427	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	2	7,730	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		2	1,241	8
9						\$	\$		\$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	2	6,004	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		2	903	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	\$ 60,726	\$ 60,726		\$	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589				14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	12,600	8,592	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		12,600	1,781	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	13,800	7,874	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		13,800	1,632	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,306,658	\$ 998,091		\$ 109,747	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
Street Address 4101 W. MAIN ST.  
City / State / Zip Code SKOKIE, IL 60076  
Phone Number ( 847) 674-1180  
Fax Number ( 847) 673-7741

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			\$	\$		\$ 110,907	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 110,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
Street Address 2201 MAIN STREET  
City / State / Zip Code EVANSTON, IL 60202  
Phone Number ( 847)328-7600  
Fax Number ( 847)3287615

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			\$	\$			1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						37,636	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		37,636	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    COLUMBUS PARK NRSG REHAB CTR                      #    0037960    Report Period Beginning:                      01/01/02                      Ending:    12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)                      YES ☒                      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization    ECM OWNERS COUNCIL  
Street Address                      6840 N. LINCOLN  
City / State / Zip Code            LINCOLNWOOD, IL. 60646  
Phone Number                      ( 847) 676-2026  
Fax Number                          (                      )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	40,000	9	\$ 150	\$	1,800	\$ 7	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	40,000	9	89		1,800	4	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	40,000	9	739		1,800	33	3
4	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	40,000	9			1,800		4
5	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	38	9	29,045	29,045	2	1,418	5
6	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	38	9	1,713		2	84	6
7	17	ADMIN. SALARY	DIRECT ALLOCATION		7	(2,635)				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 29,101	\$ 29,045		\$ 1,546	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number COLUMBUS PARK NRSR REHAB CTR # 0037960 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Mortgage		X				\$	10,800,000			\$	554,400	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	SIR Management	X		Working Capital		06/21/01		990,000	06/21/03	3.75%		36,574	6	
7	Insurance											3,615	7	
8													8	
9	TOTAL Facility Related						\$	11,790,000				\$	594,590	9
	B. Non-Facility Related*													
10	See Supplemental Schedule							20,000				5,212	10	
11	Interest Income											(21)	11	
12	Building Co Interest Income											(10,633)	12	
13													13	
14	TOTAL Non-Facility Related						\$	20,000				\$	(5,442)	14
15	TOTALS (line 9+line14)						\$	11,810,000				\$	589,148	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
1	Allocation From Preferred	X					\$					\$	1,237	1
2	Allocation From SIR Mgmt	X											3,975	2
3	Building Company			Due to tenant					20,000					3
4														4
5														5
6														6
7														7
8														8
9														9
10														10
11														11
12														12
13														13
14														14
15														15
16														16
17														17
18														18
19														19
20														20
21							\$		20,000			\$	5,212	21

**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

COLUMBUS PARK NRSG REHAB CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0037960

CONTACT PERSON REGARDING THIS REPORT

Steven Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. 16-17-401-005-0000	Long Term Care Property	\$ 43,253.73	\$ 43,253.73
2. 16-17-401-006-0000	Long Term Care Property	\$ 19,039.08	\$ 19,039.08
3. 16-17-401-026-0000	Long Term Care Property	\$ 86,949.83	\$ 86,949.83
4. See Attached	SIR Mgmt allocation	\$ 32,006.79	\$ 3,584.11
5. See Attached	Preferred Bookkeeping Allocation	\$ 16,913.82	\$ 1,907.83
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 198,163.25	\$ 154,734.58

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

COLUMBUS PARK NRSG REHAB CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0037960

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,685

B. General Construction Type: Exterior Brick Frame Number of Stories 6

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).  
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  
If so, please complete the following:

1. Total Amount Incurred:

73,435

2. Number of Years Over Which it is Being Amortized:

3

3. Current Period Amortization:

20,807

4. Dates Incurred:

4/11/02

Nature of Costs:

Closing, Engineering & Environmental

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2002	\$ 300,000	1
2					2
3	TOTALS			\$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		51,845		20	2,592	2,592	27,132	9
10	Various		1993		71,558		20	3,579	3,579	35,792	10
11	Various		1994		46,784		20	2,339	2,339	20,419	11
12	Various		1995		131,277		20	6,662	6,662	50,523	12
13	Various		1996		62,128		20	3,108	3,108	21,134	13
14	Various		1997		40,477		20	2,025	2,025	11,289	14
15	Various		1998		419,667		20	20,987	20,987	92,924	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,105,963	132,507		204,031	71,524	156,662	68
69	Financial Statement Depreciation			25,040			(25,040)		69
70	TOTAL (lines 4 thru 69)		\$ 7,929,699	\$ 157,547		\$ 245,323	\$ 87,776	\$ 415,875	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,929,699	\$ 157,547		\$ 245,323	\$ 87,776	\$ 415,875	1
2	PLUMBING WORK	1999	3,573		20	179	179	701	2
3	PAINTING	1999	29,100		20	1,455	1,455	5,578	3
4	WATER CHILLER	1999	2,211		20	111	111	398	4
5	ELEVATOR WORK	1999	58,402		20	2,920	2,920	10,463	5
6	AIR COOLED CHILLER	1999	14,147		20	707	707	2,475	6
7	ELEVATOR WORK	1999	2,780		20	139	139	487	7
8	AIR CONDITIONER	1999	77,360		20	3,868	3,868	13,538	8
9	HVAC WORK	1999	8,253		20	413	413	1,411	9
10	HOT WATER TANK	1999	3,891		20	195	195	715	10
11	SIR REMODELING	1999	12,085		20	604	604	1,963	11
12	HVAC WORK	1999	1,568		20	78	78	254	12
13	HVAC WORK	1999	1,510		20	76	76	247	13
14	BOILER	1999	10,873		20	544	544	1,768	14
15	DOORS	1999	2,376		20	119	119	476	15
16	PIPE AND WIRE	1999	1,395		20	70	70	274	16
17	BLINDS	1999	609		20	20	20	75	17
18	MIRROR OVERLAYS	1999	1,012		20	51	51	187	18
19	RETILE ELEVATORS	1999	4,912		20	246	246	882	19
20	FIRE DAMPERS	1999	956		20	48	48	168	20
21	WALLPAPER ELEVATOR	1999	1,818		20	91	91	319	21
22	ELECTRICAL WIRING	1999	2,470		20	124	124	424	22
23	COMPRESSOR	1999	1,418		20	71	71	237	23
24	TUCKPOINTING	1999	1,350		20	68	68	215	24
25	CHUTE DOORS	2000	2,887		20	144	144	420	25
26	FLOORING	2000	5,190		20	260	260	780	26
27	FLOORING	2000	2,786		20	139	139	417	27
28	BOILER WORK	2000	7,842		20	392	392	882	28
29	BOILER WORK	2000	1,605		20	80	80	213	29
30	GLASS & DOOR	2000	1,525		20	76	76	152	30
31	PAINT	2000	1,095		20	55	55	110	31
32	PAINT	2000	635		20	32	32	64	32
33	HVAC	2000	1,366		20	68	68	136	33
34	TOTAL (lines 1 thru 33)		\$ 8,198,699	\$ 157,547		\$ 258,766	\$ 101,219	\$ 462,304	34

**SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,198,699	\$ 157,547		\$ 258,766	\$ 101,219	\$ 462,304	1
2	HVAC	2000	1,112		20	56	56	112	2
3	SCREENS	2000	1,375		20	69	69	138	3
4	BOILER WORK	2001	4,903		20	245	245	429	4
5	WATER TANK	2001	2,375		20	119	119	198	5
6	PAVING	2001	3,700		20	185	185	247	6
7	ROOFING	2001	4,520		20	226	226	301	7
8	LINEN/STORAGE	2001	61,335		20	3,067	3,067	3,323	8
9	PAINT	2001	3,683		20	184	184	337	9
10	WINDOW	2001	830		20	42	42	81	10
11	SINK	2001	866		20	43	43	82	11
12	FLOORING	2001	1,093		20	55	55	101	12
13	WALLCOVER	2001	534		20	27	27	50	13
14	DOOR-PANIC DEVICE	2001	553		20	28	28	33	14
15	HOT WATER TANK	2001	1,378		20	69	69	138	15
16	HOT WATER TANK	2001	2,140		20	107	107	169	16
17	HVAC WORK	2002	3,721		20	372	372	372	17
18	HVAC WORK	2002	8,830		20	294	294	294	18
19	FREEZER DOOR	2002	2,445		20	61	61	61	19
20	DAMPERS	2002	13,700		20	228	228	228	20
21	REFRIGERATOR	2002	5,328		20	266	266	266	21
22	PAINTING	2002	1,821		20	91	91	91	22
23	NURSES STATION LIGHTS	2002	1,071		20	54	54	54	23
24	WATER HEATER	2002	2,108		20	105	105	105	24
25	VARIOUS PAINTING	2002	1,815		20	91	91	91	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,329,936	\$ 157,547		\$ 264,850	\$ 107,303	\$ 469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,329,936	\$ 157,547		\$ 264,850	\$ 107,303	\$ 469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,329,936	\$ 157,547		\$ 264,850	\$ 107,303	\$ 469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,329,936	\$ 157,547		\$ 264,850	\$ 107,303	\$ 469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,329,936	\$ 157,547		\$ 264,850	\$ 107,303	\$ 469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$8,329,936	\$157,547		\$264,850	\$107,303	\$469,605	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	216		2002		\$ 7,013,521	\$ 129,207	35	\$ 200,386	\$ 71,179	\$ 129,207	4
5			1993		29,922	950	35	855	(95)	8,122	5
6			1993		15,928	506	35	455	(51)	4,323	6
7											7
8											8
	Improvement Type**										
9	Allocation from Preferred Bookkeeping		1997		19,891	445	20	995	550	5,777	9
10	Allocation from Preferred Bookkeeping		1999		158	-	20	8	8	28	10
11	Allocation from Preferred Bookkeeping		2000		998	-	20	50	50	120	11
12											12
13	Allocation from SIR Management		1993		12,851	358	20	648	290	6,362	13
14	Allocation from SIR Management		1994		40	-	20	4	4	34	14
15	Allocation from SIR Management		1995		294	-	20	15	15	109	15
16	Allocation from SIR Management		1999		1,396	47	20	70	23	224	16
17	Allocation from SIR Management		2000		843	88	20	42	(46)	113	17
18											18
19	Allocation from SIR Properties - SIR Management		2002		119	-	20	3	3	3	19
20	Allocation from SIR Properties - SIR Management		1999		3,792	379	20	190	(189)	664	20
21	Allocation from SIR Properties - SIR Management		1998		1,812	181	20	91	(90)	408	21
22	Allocation from SIR Properties - SIR Management		1997		113	11	20	6	(5)	37	22
23	Allocation from SIR Properties - SIR Management		1994		285	7	20	14	7	121	23
24	Allocation from SIR Properties - SIR Management		1993		485	13	20	24	11	231	24
25											25
26	Allocation from SIR Properties - Preferred Bookkeeping		2002		63	-	20	2	2	2	26
27	Allocation from SIR Properties - Preferred Bookkeeping		1999		2,018	202	20	101	(101)	353	27
28	Allocation from SIR Properties - Preferred Bookkeeping		1998		964	96	20	48	(48)	217	28
29	Allocation from SIR Properties - Preferred Bookkeeping		1997		60	6	20	3	(3)	20	29
30	Allocation from SIR Properties - Preferred Bookkeeping		1994		152	4	20	8	4	64	30
31	Allocation from SIR Properties - Preferred Bookkeeping		1993		258	7	20	13	6	123	31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$7,105,963	\$132,507		\$204,031	\$71,524	\$156,662	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$335,881	\$31,048	\$31,307	\$259	10	\$219,301	71
72	Current Year Purchases	1,331,383	263,676	132,978	(130,698)	10	132,978	72
73	Fully Depreciated Assets	28,908				10	28,908	73
74								74
75	TOTALS	\$1,696,172	\$294,724	\$164,285	\$(130,439)		\$381,187	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$10,326,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$452,271	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$429,135	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(23,136)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$850,792	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions	BUILDING COM			298,607			4
5		Tower Rental Income			(9,600)			5
6		Telephone Rental Income			(1,699)			6
7	TOTAL				\$ 287,307			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 13,873 Description: Ice Maker - \$3000; Copier - \$2611; Alloc from Preferred \$3314; Allocation from SIR \$4948  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility							
		Drop-outs	Completed	Contract	Total				
1	Community College Tuition	\$	\$	\$	\$				
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$	\$	\$	\$				
10	SUM OF line 9, col. 1 and 2 (e)	\$							

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 35,163	\$		\$ 35,163	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,741			17,741	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			34,291			34,291	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				32,396		32,396	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					11,766		11,766	12
13	Other (specify): See Supplemental						30,024		30,024	13
14	TOTAL			\$		\$ 87,195	\$ 74,186		\$ 161,381	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 46,429	\$ 697,758	1
2	Cash-Patient Deposits	54,293	54,293	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,769,783	1,769,783	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,061	21,061	6
7	Other Prepaid Expenses	1,487	1,487	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	11,457	11,457	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,904,510	\$ 2,555,839	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		7,013,521	14
15	Leasehold Improvements, at Historical Cost	953,577	953,577	15
16	Equipment, at Historical Cost	463,712	1,790,191	16
17	Accumulated Depreciation (book methods)	(559,053)	(948,354)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		52,628	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 858,236	\$ 9,161,563	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,762,746	\$ 11,717,402	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 158,168	\$ 158,169	26
27	Officer's Accounts Payable	17,704	17,704	27
28	Accounts Payable-Patient Deposits	58,482	58,482	28
29	Short-Term Notes Payable	990,000	1,010,000	29
30	Accrued Salaries Payable	211,112	211,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,715	18,715	31
32	Accrued Real Estate Taxes(Sch.IX-B)	153,600	153,600	32
33	Accrued Interest Payable	1,159	43,159	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,500	13,500	35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	201,851	201,851	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,824,291	\$ 1,886,292	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,800,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 10,800,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,824,291	\$ 12,686,292	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 938,455	\$ (968,890)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,762,746	\$ 11,717,402	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 939,901	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 939,901	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	337,754	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(339,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,446)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 938,455	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,003,879	1
2	Discounts and Allowances for all Levels	12,508	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,016,387	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,220	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 252,220	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,145	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,189	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,893	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 65,227	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	21	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 21	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	11,609	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,609	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,345,464	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,237,944	31
32	Health Care	2,565,147	32
33	General Administration	1,686,162	33
	<b>B. Capital Expense</b>		
34	Ownership	1,238,816	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	161,381	35
36	Provider Participation Fee	118,260	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,007,710	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	337,754	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 337,754	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,535	1,800	\$ 59,651	\$ 33.15	1
2	Assistant Director of Nursing	2,073	2,225	57,535	25.86	2
3	Registered Nurses	18,353	19,572	408,000	20.85	3
4	Licensed Practical Nurses	28,854	31,593	583,641	18.47	4
5	Nurse Aides & Orderlies	109,156	115,812	877,222	7.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,814	5,145	115,875	22.52	8
9	Activity Director	1,989	2,086	25,216	12.09	9
10	Activity Assistants	10,469	11,059	68,988	6.24	10
11	Social Service Workers	2,979	3,217	98,035	30.47	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,142	34,867	16.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,548	23,941	182,586	7.63	15
16	Dishwashers					16
17	Maintenance Workers	3,992	4,255	41,428	9.74	17
18	Housekeepers	23,242	24,929	175,285	7.03	18
19	Laundry	8,541	9,251	68,652	7.42	19
20	Administrator	1,933	2,086	71,808	34.43	20
21	Assistant Administrator	1,701	1,916	35,943	18.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,294	7,927	102,925	12.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,552	5,097	83,723	16.43	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	255,987	274,051	\$ 3,091,380 *	\$ 11.28	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,800	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	Monthly	42,768	10-03	38
39	Pharmacist Consultant	Monthly	1,020	10-03	39
40	Physical Therapy Consultant	90	4,839	10a-03	40
41	Occupational Therapy Consultant	90	4,879	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	505	10a-03	43
44	Activity Consultant	82	3,866	11-03	44
45	Social Service Consultant	72	3,572	12-03	45
46	Other(specify)				46
47	Dir of Food Service	Monthly	22,032	01-03	47
48					48
49	TOTAL (lines 35 - 48)	343	\$ 101,409		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	239	\$ 8,533	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	239	\$ 8,533		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Martin Lee	Administrator	0	\$ 71,808	Workers' Compensation Insurance		\$ 47,439	IDPH License Fee		\$		
Jaime Lloyd	Asst Admin	0	35,943	Unemployment Compensation Insurance		29,505	Advertising: Employee Recruitment		5,023		
				FICA Taxes		232,180	Health Care Worker Background Check		1,827		
				Employee Health Insurance		185,603	(Indicate # of checks performed 261 )				
				Employee Meals		28,908	IL Council on LTC		6,864		
				Illinois Municipal Retirement Fund (IMRF)*			Promotional Advertising		3,870		
				Chicago Head Tax		7,464	Yellow Page Advertising		6,680		
				Employee Life Insurance		245	Licenses & Fees		3,406		
				401k EMPLOYER EXPENSE		1,794	Alloc from Pref BKPNG		228		
				EMPLOYEE BENEFITS		21,493	Alloc from SIR Mgmt		20		
							Less: Public Relations Expense	(			
							Non-allowable advertising		(3,870)		
							Yellow page advertising		(6,680)		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 107,751	TOTAL (agree to Schedule V, line 22, col.8)		\$ 554,631	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,368		
(List each licensed administrator separately.)											
B. Administrative - Other											
Description			Amount								
Management Fees - see attached			\$ 442,346								
Management Service Fees - see attached			75,816								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 518,162	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)											
C. Professional Services				Description	Line #	Amount	Description	Amount			
Vendor/Payee	Type		Amount								
Preferred Bookkeeping	Accounting		\$ 28,050			\$	Out-of-State Travel	\$			
Frost, Ruttenberg & Rothblatt	Accounting		18,290								
Personnel Planners	Unemployment Consultant		2,745								
IOC Solutions	Computer Support		135				In-State Travel				
SIR Management	Dir of Regulatory Services		17,496								
Michael Best & Friedrich	Legal		21,119								
Stuart Sikes	Legal		237								
Scott Forest Stern	Legal		315				Seminar Expense	2,993			
Aronberg, Goldgehn Davis &Gar	Legal		980				Alloc from Pref BKPNG	45			
Preferred Bookkeeping	Bookkeeping		77,760				Alloc from SIR Mgmt	234			
Preferred Bookkeeping	Computer Services		5,184								
SIR Management	Legal		7,776				Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 180,087	TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL		\$ 3,272		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		COLUMBUS PARK NRSG REHAB CTR	STATE OF ILLINOIS	#	0037960	Report Period Beginning:	01/01/02	Ending:	12/31/02	Page 23
XX. GENERAL INFORMATION:										
(1)	Are nursing employees (RN,LPN,NA) represented by a union?					<u>Yes</u>				
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.					<u>Yes</u> <u>IL Council on LTC \$9880</u>				
(3)	Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report?					<u>Yes</u>				
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity?									
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?					<u>Yes</u> <u>10 years</u>				
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line					<u>10</u>				
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.									
(8)	Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease.									
(9)	Are you presently operating under a sublease agreement?					YES <u>X</u> NO				
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.									
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>118,260</u> This amount is to be recorded on line 42 of Schedule V.									
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.									
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?					<u>Yes</u>				
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.									
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>28,908</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____									
(16)	Travel and Transportation									
	a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.									
	b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____									
	c. What percent of all travel expense relates to transportation of nurses and patients? <u>None</u>									
	d. Have vehicle usage logs been maintained? <u>No</u>									
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>									
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>									
	g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____									
(17)	Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____									
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u>									
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees									

SEE ACCOUNTANTS' COMPILATION REPORT